MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission
Board Meeting

May 1, 2019

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Call to Order**
- Approval of Minutes from April 3, 2019 Meeting
- Market Oversight and Transparency
- Care Delivery Transformation
- Research and Publications
- Schedule of Next Board Meeting

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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on April 3, 2019 as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

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- Call to Order
- Approval of Minutes from April 3, 2019 Meeting
- **Market Oversight and Transparency**
  - Notices of Material Change
  - State Conditions for Beth Israel Lahey Health Merger
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Types of Transactions Noticed

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Clinical affiliation	22	22%
Acute hospital merger, acquisition, or network affiliation	21	21%
Physician group merger, acquisition, or network affiliation	20	20%
Formation of a contracting entity	18	18%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	12	12%
Change in ownership or merger of corporately affiliated entities	5	5%
Affiliation between a provider and a carrier	1	1%

Notice Currently Under Review

Received Since 4/3

- Proposed provider partnership for joint contracting by **Emerson Hospital**, **Harrington HealthCare System**, **Heywood Healthcare**, **Holyoke Medical Center**, **Signature Healthcare Corporation**, **South Shore Health System**, and **Sturdy Memorial Hospital**, through the Massachusetts Value Alliance (MVA). The MVA would engage in population health management and risk-based payer contracting on behalf of the parties.

Elected Not to Proceed

- Proposed acquisition of **New England Geriatrics (NEG)** by **HealthDrive Corporation**.
  - Our analysis suggested limited scope for changes in health care spending.
  - HealthDrive has stated that it serves all patients, including MassHealth patients, in a non-discriminatory manner, without regard to their insurance status, and that it plans to continue this approach at this time.
  - We did not review evidence indicating that the transaction is likely to negatively impact clinical quality.

- Proposed joint venture between **Baystate Medical Center** and **Beach Health Development**. The proposed joint venture, B2 Health, would own and operate a new psychiatric hospital in western Massachusetts.
  - Our analysis suggested limited scope for changes in health care spending.
  - We did not review evidence indicating that the transaction is likely to negatively impact clinical quality or access to health care.

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The HPC's final Cost and Market Impact Report of Beth Israel Lahey Health (BILH) included a referral to the Attorney General and the Department of Public Health for further review

- The HPC was not required to refer this transaction to the Attorney General. However, under the HPC's regulations, it **elected to refer** its report to the Attorney General to consider further action on the basis of the findings in the Final Report.

- Under the Determination of Need (DoN) regulations, the HPC **also recommended** to the Commissioner of Public Health that the Department reconsider its approval with conditions of the parties' DoN application.

In October 2018, the Public Health Council approved a revised set of DoN conditions for the BILH merger

- Conditions are in effect for 10 years, and include annual reporting on:
  - **Payer mix and network participation** (for each subsidiary as well as system-wide)
  - **Care delivery, access improvement**, and **data system integration** efforts
  - Efforts to **reduce community-appropriate care at BILH AMCs**
  - Plan for how **internal savings from the merger** will be used to improve **quality** and **access**
  - Whether BILH has been referred by CHIA to the HPC through the **PIPs** process

- If BILH is referred by CHIA to the HPC through the PIPs process, and if the growth in BILH's weighted average TME across all payers is above the cost growth benchmark, BILH would have to develop a plan to **invest a portion of the amount above the benchmark** in support of its BH and primary care services and its affiliated community hospitals and CHCs.

Note: HPC staff summary; does not necessarily reflect the position of the Department of Public Health. Please refer to original documents for complete text.

DoN conditions require BILH to expand MassHealth access and be subject to a potential review by the HPC after five years

- BILH must develop a plan to address its **low MassHealth payer mix** and use good faith efforts to ensure that its MassHealth payer mix (excluding contracting affiliates and DSH hospitals) **does not decrease**.

- BILH must develop a plan through which, within two years, all **employed providers shall have applied to participate in MassHealth**, and to annually certify ongoing compliance with the intent of the plan.

- If the HPC has not otherwise conducted a Cost and Market Impact Review (CMIR) of BILH within five years after the merger is completed, **DPH will request that the HPC conduct a CMIR**, and the findings of the CMIR will be used by DPH to determine BILH's compliance with its conditions.

Note: HPC staff summary; does not necessarily reflect the position of the Department of Public Health. Please refer to original documents for complete text.

In November 2018, the Attorney General's Office reached a settlement agreement with the parties, allowing the BILH merger to move forward with certain conditions

- Agreement is in effect for 10 years, with different time periods for different elements.
- Price Growth Cap (seven years):
  - BILH price growth (including for hospitals and physicians) will be limited to the health care cost growth benchmark minus 0.1% (and the cap cannot be lower than 3.0%). **Currently, this is 3.0%.**
  - The cap does not apply to **Lawrence General** or **Cambridge Health Alliance (CHA)**.
  - The cap applies to **alternative payment method** contracts that include fee-for-service prices. If an agreement cannot be reached on an APM contract, the payer can fall back on a fee-for-service contract that complies with the cap.
  - In Medicare Advantage plans, **the percent of traditional Medicare** paid by the managed care plan to BILH in the previous year cannot increase (unless the payer agrees to an increase and the AGO consents).
- MassHealth Requirements:
  - BILH providers who currently accept MassHealth must continue to do so. BILH must make a good faith effort to have all its providers apply to participate in MassHealth.
  - BILH, and New England Baptist in particular, must conduct **marketing campaigns** to increase their number of MassHealth patients.

Note: HPC staff summary; does not necessarily reflect the position of the Office of the Attorney General. Please refer to original documents for complete text.

The AGO agreement includes required investments and is subject to compliance oversight by a third-party monitor

- Support for Community Health Centers (CHCs), Safety Net Hospitals, Underserved Populations, and Behavioral Health (generally eight years):
  - BILH must make good-faith efforts to **maintain its current affiliations** with CHCs, Lawrence General, CHA, and Signature Brockton.
  - BILH must obtain **price increases** for Lawrence General, CHA, and lower-priced BILH hospitals that are **equal to or greater than** the overall BILH price increase.
  - **Restrictions against recruiting certain physicians** from safety net hospitals and CHCs.
  - **Specified financial support** for: BILH's CHC affiliates, Lawrence General, CHA, and Signature Brockton; expanded access for communities of color and low-income communities; and behavioral health services.
- Reporting, Monitoring, Petition to Amend (generally ten years; partially public):
  - **Annual reporting** of data and analyses to the AGO; can be shared with the HPC.
  - BILH will propose and pay for a **third-party monitor** that will produce an annual report assessing BILH's compliance.
  - If BILH complies with the agreement for five years, it may **petition the AGO to amend** its obligations.

HPC

Note: HPC staff summary; does not necessarily reflect the position of the Office of the Attorney General. Please refer to original documents for complete text.

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- **Care Delivery Transformation**
  - Academic Detailing Program
  - SHIFT-Care Challenge Investment Program Launch
- Research and Publications
- Schedule of Next Board Meeting

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Statutory Authorization for the HPC's Academic Detailing Program

The FY2019 state budget provides $150,000 for the HPC to develop and implement an academic detailing program for Massachusetts providers.

"1450-1266. For the operation of an **evidence-based outreach and education program designed to provide information and education on the therapeutic and cost-effective utilization of prescription drugs** to physicians, pharmacists and other health care professionals authorized to prescribe and dispense prescription drugs; provided, that **the health policy commission shall work with the office of Medicaid to access prescription data** aggregated by provider on an ongoing basis for the use of the program; … and provided further, that funds shall be set aside from this appropriation to evaluate programs **and assess the effectiveness of and cost savings** associated with this program."

HPC

What is academic detailing?

Academic detailing is **non-commercial, educational outreach** to health care providers by qualified personnel. The purpose of academic detailing is to encourage and train providers to use best practices to improve quality of care and patient outcomes.[1, 2, 3]

One-on-one provider guidance/education

Structured similarly to pharmaceutical sales techniques but focuses on unbiased, evidence-based content – not marketing materials.

Proven to influence prescribing

Studies indicate academic detailing can alter prescribing behavior of providers who receive one-on-one educational visits, compared to providers receiving only written materials.[4, 5, 6]

May support value-based care

Academic detailing may help providers meet quality measurement targets as well as cost benchmarks.

[1] Centers for Disease Control. Academic Detailing: Frequently Asked Questions. 2014 https://www.cdc.gov/tobacco/quit_smoking/cessation/pdfs/academic-detailing-faq.pdf;
[2] Yeh, J. et al. Key features of academic detailing: development of an expert consensus using the Delphi Method. Am Health Drug Benefits, 2016 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4822978/
[3] Sullivan, T. AHRQ National Resource Center for Academic Detailing. Policy & Medicine, 2018. https://www.policymed.com/2011/11/ahrq-national-resource-center-for-academic-detailing.html
[4] Avorn, J, S. Soumerai, New England Journal of Medicine 1983 https://www.nejm.org/doi/pdf/10.1056/NEJM198306163082406;
[5] O'Brien et al, Educational Outreach Visits: effects on professional practice and healthcare outcomes. Cochrane Systematic Review, 2007. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000409.pub2/full;
[6] Patel, B. Back to school: quality improvement through academic detailing. Am Health Drug Benefits, 2011. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4106497/

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Approach to Implementing an Academic Detailing Program

Program approach

- Provide academic detailing as a technical assistance opportunity for HPC-certified ACOs
  - Pharmacy remains a challenging cost growth area for providers
  - Evidence-based prescribing aligns with ACO investments in value-based care delivery
  - HPC-certified ACOs collectively serve ~2.86 million patients in the Commonwealth
- Procure an expert organization to deliver academic detailing services

Program implementation: Three phases

Academic Detailing Program: Initial Stakeholder Engagement

Winter 2019 stakeholder engagement informed procurement:
The HPC sought input from HPC-certified ACOs and MassHealth on current pharmacy management approaches, data needs and capabilities, and program interest

Key points of feedback:

- ACOs have access to some pharmacy data, but usability and analytic capacity varies
  - Timely, accurate, consistent data is a key concern for ACOs

- ACOs expressed general interest in the program
  - Importance of having detailers with clinical expertise (PharmD, MD, APRN, etc.)
  - Mixed opinions on preferred program design
    - "Direct Academic Detailing" – direct educational visits to ACO clinicians
    - "Train the Detailer" – training for ACO staff in academic detailing skills

Academic Detailing Program: Procurement of Expert

Request for Response: Key components

- Preference for proposals that demonstrated clinical expertise and experience providing detailing services; value to ACOs and the Commonwealth; and ability to assess program impact
- Respondents asked to propose designs for both Direct and Train the Detailer approaches

Results

Selection of a contractor with:

- High-value proposal: significant portion of budget devoted directly to providing services to ACOs
- Significant experience and expertise: national leader in academic detailing services
- Well-developed clinical materials and ability to engage expert detailers/trainers
- Ability to support a range of ACOs

Academic Detailing Program: Program Delivery

April – May: Finalize program design

- Complete contracting process
- Survey ACOs on preferences for approach, clinical focus, etc.
- Determine final design in collaboration with contractor

June – July: Identify ACOs to participate

- Host webinar to announce the program and invite ACO participation
- Implement an application process for ACOs wishing to participate

August 2019 – June 2020: Launch and implement program

- Contractor to work directly with ACOs to identify specific clinicians and/or staff to engage
- Approximately eight months of educational visits and/or ACO staff training
- Regular status updates and implementation reports from contractor

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  - **SHIFT-Care Challenge Investment Program Launch**
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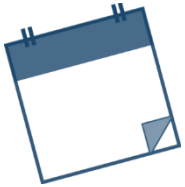
The SHIFT-Care Challenge is a $10 million competitive funding opportunity to support and scale promising ideas to reduce avoidable acute care use

Reducing avoidable acute care utilization by investing in innovative care delivery models that are community-based, collaborative, and sustainable

- **Care model design and impact**
- **Organizational leadership, strategy, and demonstrated need**
- **Evaluation**
- **Sustainability and scalability**
- **Preference provided to CHART-eligible hospitals and HPC-certified ACOs and ACO participants**

15 awards made ranging from $486,580 to $750,000 per award. Applicants are responsible for at least 25% in-kind financial contribution



21 months (3 months of preparation and 18 months of implementation)

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SHIFT-Care sought proposals that addressed the whole-person needs of patients through two innovative care models

Innovative Model 1: Addressing health-related social needs

- Support for innovative models that **address health-related social needs** of complex patients in order to prevent a future acute care hospital visit or stay
- 5 awards made totaling $3,288,234.49

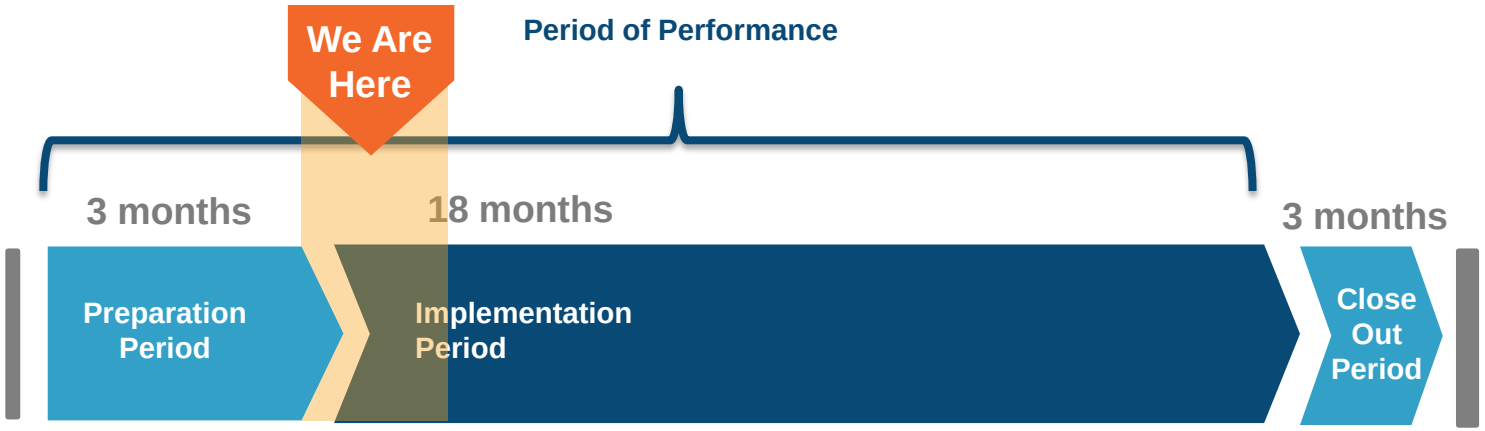
Innovative Model 2: Addressing behavioral health needs

- Support for innovative models that **address the behavioral health care needs** of complex patients in order to prevent a future acute care hospital visit or stay
- 10 awards made totaling $6,467,066.02

OUD FOCUS: Enhancing opioid use disorder (OUD) treatment

- Support for innovative models that expand access to opioid use disorder treatment by **initiating pharmacologic treatment in the ED** and connecting patients to community-based BH services

SHIFT-Care Program Timeline



Current State:

- All 15 awardees active
- HPC staff are engaging 3 awardees in Preparation Period activities and 12 awards in Implementation Period activities
- External evaluator for pharmacologic treatment in the ED awards (Brandeis) is engaging with 9 awardees on baseline data collection and measure specifications

Next Steps:

- HPC staff have conducted 4 site visits and plan more in the near future
- Awardees will begin submitting quantitative baseline data by end of month, and qualitative data this summer

SHIFT-Care Challenge Launch Visit to Holyoke Health Center – April, 2019

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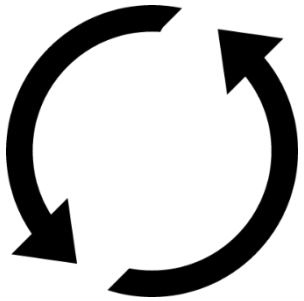
The HPC promotes two priority policy outcomes that contribute to reducing health care spending, improving quality, and enhancing access to care

Strengthen market functioning and system transparency



The two policy priorities reinforce each other toward the ultimate goal of reducing spending growth

Promoting an efficient, high-quality delivery system with aligned incentives

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Market Oversight and Transparency: Ongoing Research Projects for 2019

- **Pharmaceutical Spending**
  - Insulin price growth and diabetic patient costs (**see slides 37 – 43**) - ***AVAILABLE TODAY***
  - Alternative drug distribution channels, i.e., white bagging and brown bagging
  - Use and impact of prescription drug coupons (**see slides 45 – 50**)
  - Pharmacy Benefit Manager (PBM) markups on generic drugs
- **Out-of-Network (OON) Billing**
  - Modeling default payment options
  - Update on prevalence and impact of OON billing
- **Health Care Market Retrospective** (**see slides 52 – 55**)
- **Hospital Outpatient Spending Growth**
  - Prices, utilization, and shifts from other care settings
- **Provider Organization Performance Variation**
  - Factors contributing to high-cost and low-value care
  - Factors contributing to hospital admissions from the ED
- **Avoidable ED Use**
  - Resident survey to understand root causes
- **Administrative Complexity**
  - Identify areas of administrative complexity without value (*to be discussed further at the July Board meeting)*

Care Delivery Transformation: Ongoing Research Projects for 2019

- **Behavioral Health**
  - *Report on the Statewide Availability of Health Care Providers that Serve Patients with Co-Occurring Substance Use Disorder and Mental Illness* (**see slides 57 – 70**) – ***AVAILABLE TODAY***
  - Update on prevalence and impact of opioid use disorder related hospital utilization
  - Update on prevalence and impact of neonatal abstinence syndrome
- **HPC ACO Certification Program**
  - ACO risk contracts and performance management approaches (**see slide 34**)
- **HPC Investment Programs**
  - Awardee profiles for all Health Care Innovation Investment participants
  - Awardee profiles for all SHIFT-Care Challenge Investment participants
  - Telemedicine for Behavioral Health Guide (**see slide 35**)
  - Playbook of best practices from the CHART Investment Program
  - CHART Investment Program summary and impact assessment
  - Health Care Innovation Investment Program summary and impact assessment
- **Primary Care Workforce**
  - Utilization and cost/quality/access impacts of primary care nurse practitioners
- **Alternative Payment Methodologies**
  - Assessment of barriers to adoption
- **Administrative Complexity**
  - Identify areas of administrative complexity without value (*to be discussed further at the July Board meeting)*

Coming Soon: ACO Certification Policy Brief #3

Transforming Care: Risk Contracts and Performance Management Approaches of Massachusetts ACOs

- HPC-certified ACOs **collectively hold 85 risk contracts** with public and commercial payers, of which **26 are "upside only" contracts**
- The **number of quality measures** included in individual payer contracts **ranges from zero to 51**
- The majority of ACOs **share performance reports** among their clinician leadership on a **monthly or quarterly basis**
- When distributing shared savings among their participating providers, most ACOs consider performance on **quality, efficiency, and cost**; some also consider **patient satisfaction and adoption of health information technology**

MASSACHUSETTS HEALTH POLICY COMMISSION

MAY 2019

ACO POLICY BRIEF

Transforming Care: Risk Contracts and Performance Management Approaches of Massachusetts ACOs

As health care providers organize as accountable care organizations (ACOs) and assume responsibility for the total cost of care and health outcomes for their patients, successful providers and payers alike are implementing strategies to improve the underlying health of the population served. This emerging focus on addressing the needs of a defined population, as opposed to those of an individual patient, is reflected in the development of population health management (PHM) programs. These programs are commonly delivered by an ACO and its community partners, informed by an assessment of the risk and health needs of the populations, and supported by reformed payment and claims data from health plans.

As ACOs more effectively assess the health and needs of their patients, there is an increasing focus on addressing non-medical needs of the population through the integration of physical, behavioral, and social determinants of health (SDH).[1,2,3] The SDH are "the structural determinants and conditions in which people are born, grow, live, work and age,"[4] and mounting evidence suggests that addressing patients' social needs impacts health outcomes and total health care spending.[5,6,7,8,9] This is particularly true for the most complex patients—those with additive risk of comorbid medical, behavioral, and social needs, such as a patient with cardiovascular disease, substance use disorder, and unstable housing. One study found that environmental surroundings, socio-economic factors, and individual activity account for nearly two-thirds of morbidity and premature mortality.[10]

The Health Policy Commission (HPC) recognized the importance of improving population health in issuing statewide standards for certifying Massachusetts ACOs, under which the HPC certified 17 ACOs in 2017.[i] These standards require ACOs to demonstrate all-payer capabilities in population health, including risk stratification of the patient population and program implementation to address identified needs regarding behavioral health and the SDH.

This policy brief, the second in a series,[11] defines the HPC's PHM requirements for ACO Certification, summarizes the certified ACOs' responses to those requirements, and concludes with a discussion of the policy implications of the findings.[12]

HPC standards require ACOs to demonstrate that their governing body assesses performance and sets strategic performance improvement goals at least annually; and reviews a performance dashboard that includes at least one quality measure in the domains of process, efficiency, outcomes, and patient experience of care

i The 2017 certified ACOs are: Atrius Health, Inc.; Baycare Health Partners, Inc.; Beth Israel Deaconess Care Organization; Boston Accountable Care Organization, Inc.; Cambridge Health Alliance; Children's Medical Center Corporation; Community Care Cooperative, Inc.; Health Collaborative of the Berkshires, LLC; Lahey Health System, Inc.; The Mercy Hospital, Inc.; Merrimack Valley Accountable Care Organization, LLC; Partners HealthCare System, Inc.; Reliant Medical Group, Inc.; Signature Healthcare; Southcoast Health System, Inc.; Steward Health Care Network, Inc.; Wellforce, Inc. For more information on the certified ACOs and the ACO Certification program, visit: https://www.mass.gov/service-details/the-hpc-accountable-care-organization-aco-certification-program

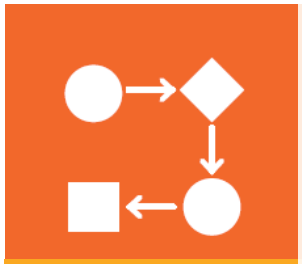
ACO Policy Brief | 1

HPC

Coming Soon: Telemedicine for Behavioral Health Guide

Telemedicine for Behavioral Health Guide

Based on the HPC's knowledge sharing session and roundtable discussion on telemedicine for behavioral health (teleBH) in 2018, this guide covers four key areas of teleBH program development: Workflow, Data and Measurement, Workforce, and Technology.



Develop a risk management plan for troubleshooting technological difficulties

"Make sure you have a signal [and] that your wifi works. There is nothing worse than having psychiatrically compromised clients on tele and all of a sudden you lose signal—that can be actually quite dangerous, let alone frustrating."

—UMASS MEMORIAL MEDICAL CENTER

Expose behavioral health providers to teleBH technology to normalize it and increase their comfort with the modality

"I'm working on developing—with the dean of a school of social work—a certificate class in tele-behavioral counseling so students will actually be trained and have the opportunity to be comfortable with the modality."

– HEYWOOD HOSPITAL

Prepare for the ways that teleBH will enhance you interactions beyond just accessibility

"We are reaching people who would otherwise not be receiving care. They face barriers related to transportation in very rural counties or anything associated with stigma, shame or fear... [teleBH] removes those barriers and that is huge."

—BERKSHIRE MEDICAL CENTER

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DataPoints, Issue #11: Insulin Price Growth and Patient Out-of-Pocket Spending

Background

- Spending on prescription drugs has been among the fastest growing categories of health care spending in recent years

- Affordability of insulin is a focus of concern, as patients who require insulin must receive regular injections to regulate their blood sugar
  - Without adequate insulin, patients may encounter serious health consequences including long-term disability and death
  - A recent study found that one quarter of patients used less insulin than prescribed due to high costs (Herkert, et al., 2019)

HPC

Source: Herkert D, Vijayakumar P, Luo J, et al. Cost-Related Insulin Underuse Among Patients With Diabetes. *JAMA Intern Med.* 2019;179(1):112–114.

DataPoints, Issue #11: Research Methods

Approach

- The HPC used the All-Payer Claims Database (APCD) to identify commercially-insured individuals who had at least one pharmacy claim for any insulin product in each of the study years from 2013 to 2016
- Study population was limited to individuals who had a diabetes chronic disease indicator from the Johns Hopkins DRG grouper, an ACG risk score less than five, and were continuously enrolled for each year of study
- Over 9,000 commercially-insured beneficiaries were included for each year

Analyses

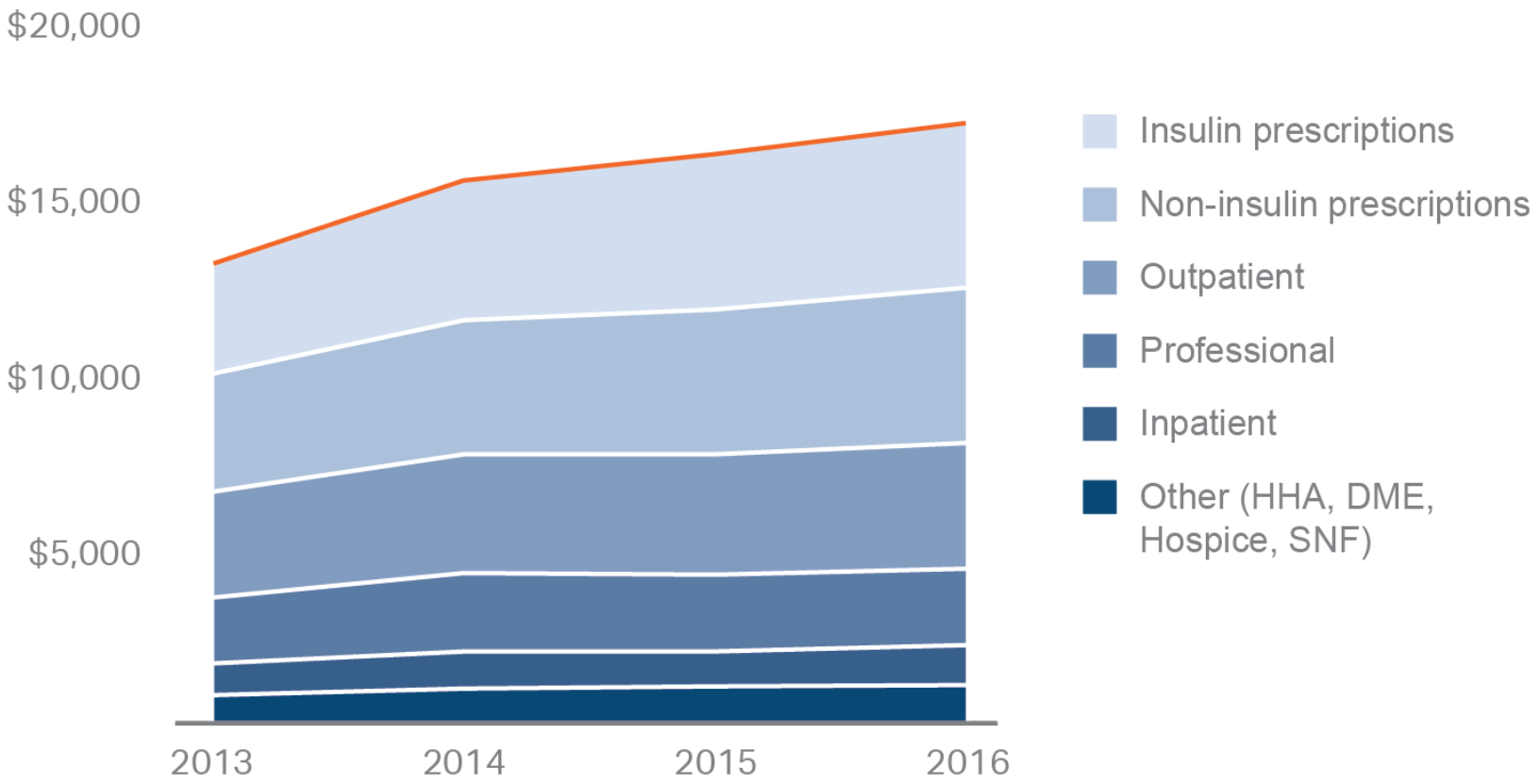
- Growth of total health care spending and categories of spending over time
- Insulin product price growth by manufacturer and delivery mechanism (***NEW***)
- Distribution of out-of-pocket spending over time
- Regional variation in relative burden of out-of-pocket health care spending (***NEW***)

Limitations

- Analysis reflects prices at the point of sale and does not include rebates or other manufacturer discounts that occur after the point of sale; however, cost-sharing is typically based on list prices for patients with deductibles or co-insurance

(Tableau Demo) From 2013 to 2016, insulin spending was the largest contributor to health care spending growth for Massachusetts residents who use insulin to manage their diabetes

Category of spending and contribution to total health care spending per person per year, 2013-2016



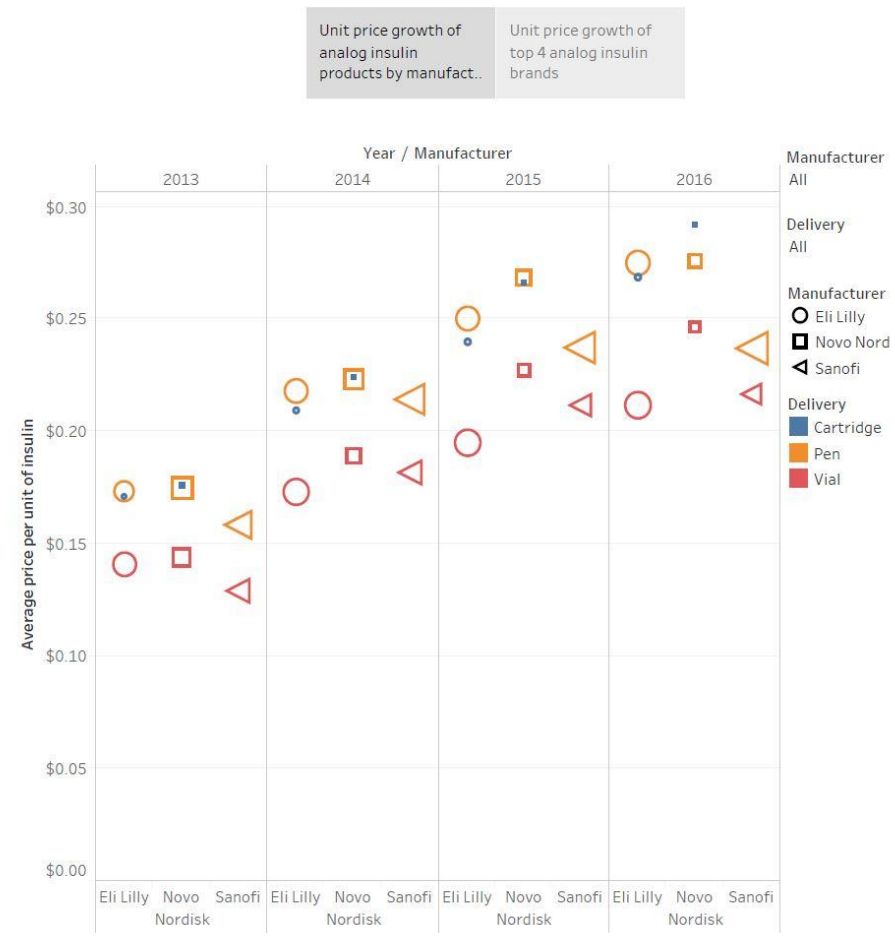
Notes: 'Other' category includes spending on home health assistance, durable medical equipment, hospice care, and care received in a skilled nursing facility. Spending categories defined by the Health Care Cost Institute (HCCI). Drug prices do not reflect rebates that occur after the point of sale.

Sources: *Sources: HPC analysis of the Massachusetts All-Payer Claims Database, 2013-2016; AHFS Clinical Drug Information, 2016; The Johns Hopkins ACG® System*; HCCI January 2019 brief.

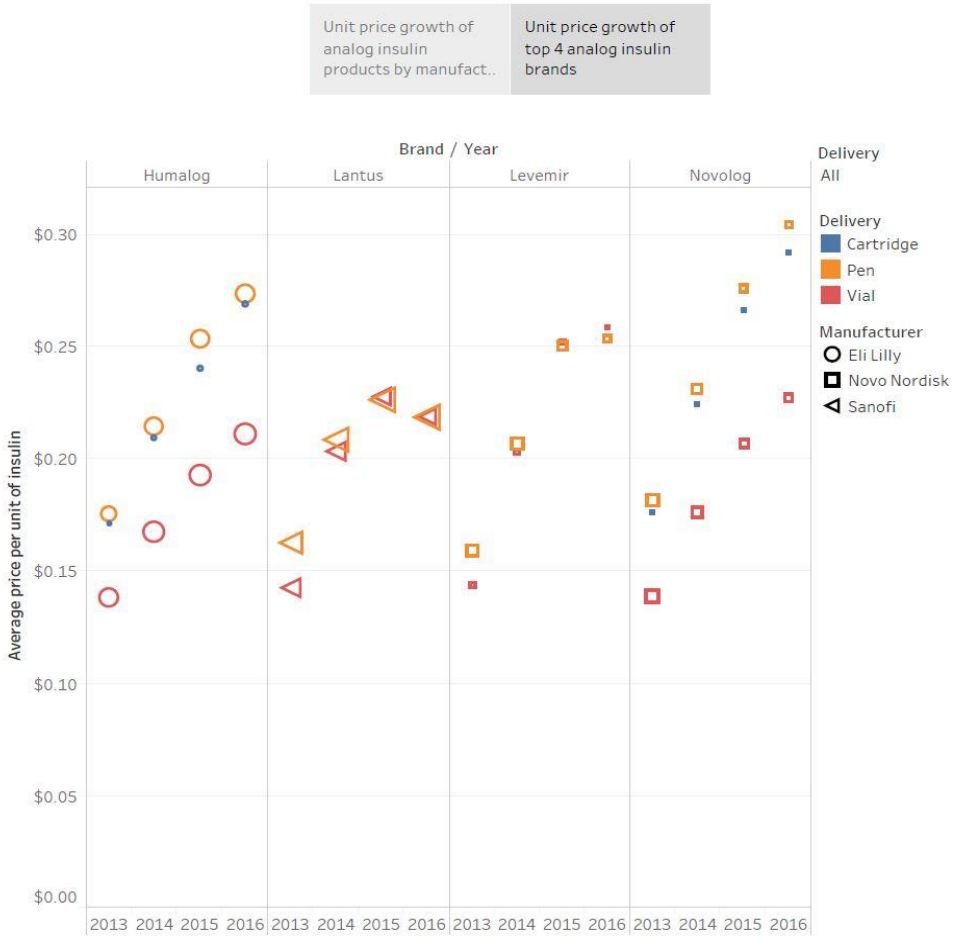
(Tableau Demo) The mean price per unit of insulin across all products increased from 15 cents in 2013 to 23 cents in 2016; price growth was similar among top manufacturers

Focus on the price growth of analog insulin by product, delivery method, and manufacturer, 2013-2016

Average price per unit of analog insulin, 2013-2016



Average price per unit of analog insulin, 2013-2016

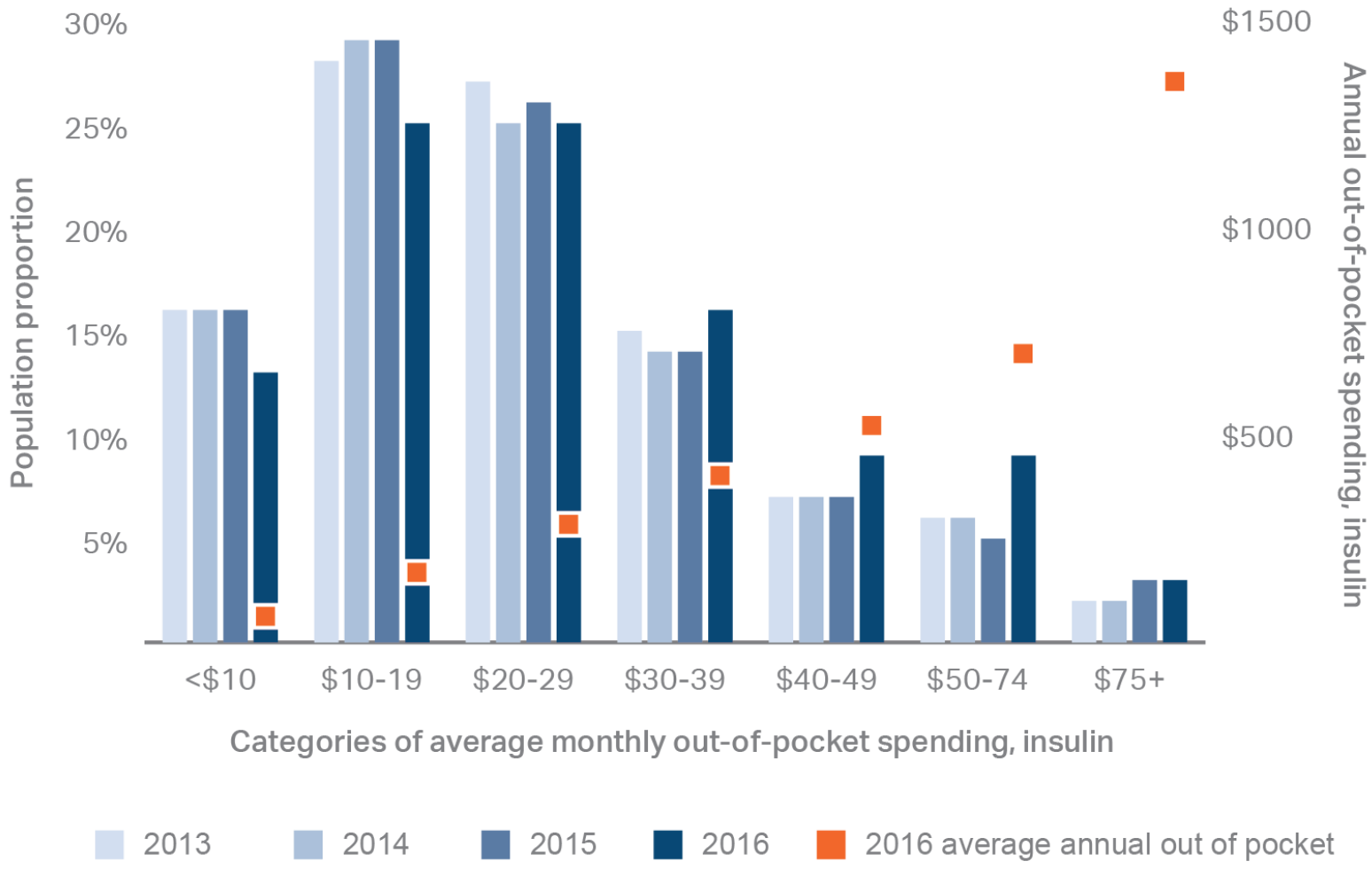


Note: Drug prices do not reflect rebates that occur after the point of sale.

Sources: HPC analysis of the Massachusetts All-Payer Claims Database, 2013-2016; AHFS Clinical Drug Information, 2016; The Johns Hopkins ACG® System

(Tableau Demo) By 2016, average monthly out-of-pocket spending for insulin was $28

Distribution of out-of-pocket insulin spending, 2013-2016

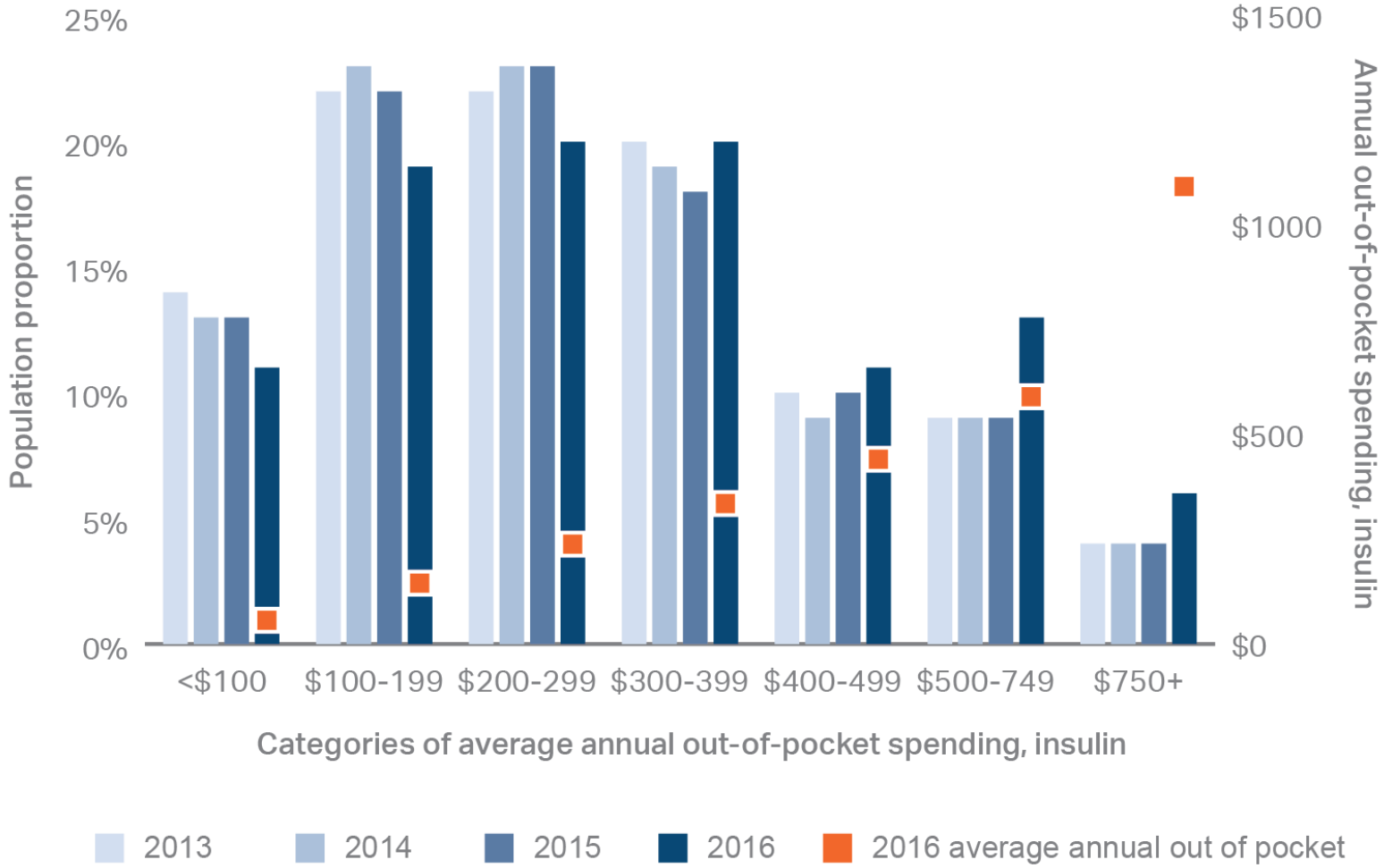


HPC

Sources: HPC analysis of the Massachusetts All-Payer Claims Database, 2013-2016; AHFS Clinical Drug Information, 2016; The Johns Hopkins ACG® System

(Tableau Demo) By 2016, average annual out-of-pocket spending for insulin was $340; 18% of individuals paid more than $500

Distribution of out-of-pocket insulin spending, 2013-2016

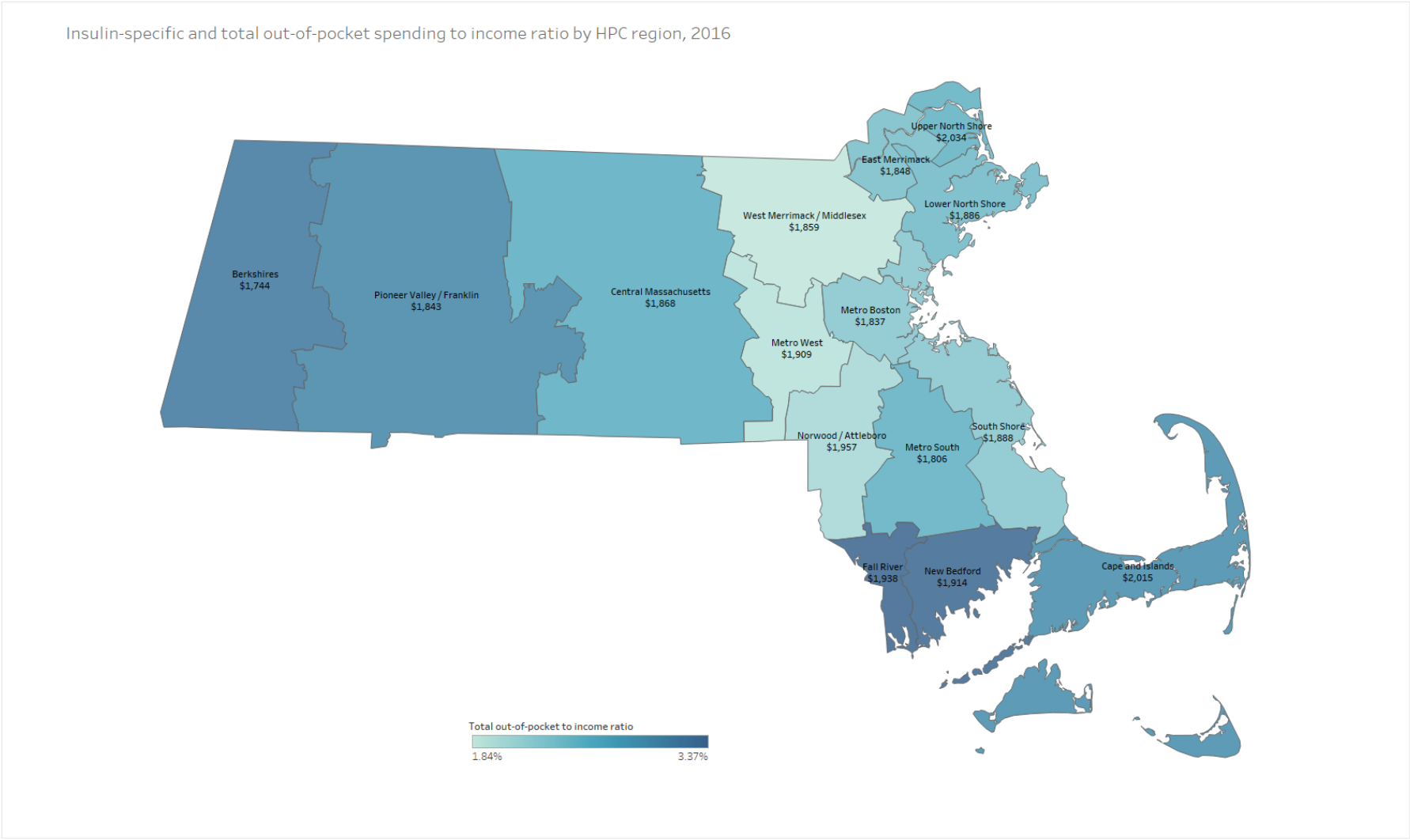


HPC

Sources: HPC analysis of the Massachusetts All-Payer Claims Database, 2013-2016; AHFS Clinical Drug Information, 2016; The Johns Hopkins ACG® System

(Tableau Demo) Out-of-pocket spending for insulin as a ratio of average community income varied somewhat by region suggesting potential affordability challenges

Focus on insulin-specific and total out-of-pocket spending to income ratio by HPC region, 2016



Sources: HPC analysis of the Massachusetts All-Payer Claims Database, 2013-2016; American Community Survey, 2016; AHFS Clinical Drug Information, 2016; The Johns Hopkins ACG® System

DataPoints, Issue #11: Summary Findings

- Annual health care spending increased by $4,016 (31%) per person between 2013 and 2016 for individuals who use insulin to manage their diabetes
- Annual spending on insulin for this population increased by $1,562 (50%), accounting for 39% of the total spending increase
- In 2016, average out-of-pocket spending for insulin was $28 per month, or $340 per year; 18% of individuals paid more than $500 annually on insulin
- Prices trended upward across all three major manufacturers and all insulin products from 2013-2016
- Although residents paid relatively similar amounts out-of-pocket for their care, the affordability of care varied by region

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes from April 3, 2019 Meeting
- Market Oversight and Transparency
- Care Delivery Transformation
- Research and Publications
  - 2019 Ongoing Research Projects
  - DataPoints Issue #11: Insulin Affordability
  - **Prescription Drug Coupon Study**
  - Health Care Market Retrospective Study
  - Co-Occurring Disorders Report
- Schedule of Next Board Meeting

Background on Authorization of Prescription Drug Coupons in the Commonwealth

Definition

- Prescription drug coupons or vouchers offered by manufacturers reduce the amount of a patient's cost-sharing, as established by the patient's insurance plan
- Public payers (e.g., Medicare, Medicaid, VA) do not allow the use of drug coupons

Legislative History

- Chapter 139 of the Acts of 2012 authorizes drug manufacturers to provide consumers with drug coupons and vouchers
  - Continues ban on drug coupons for AB rated generic equivalents
  - Sunsets the authorization of drug coupons (January 2015)

- In 2014 and 2016, the Legislature delayed the sunset on drug coupon authorization

- Chapter 363 of the Acts of 2018 delays the sunsets until January 1, 2020, and directs the HPC to conduct a study on the matter by June 1, 2019

Statutory language directing the HPC to complete a study on use of prescription drug coupons in the Commonwealth

Chapter 363 of the 2018 Session Laws, ***An Act Extending the Authorization for the Use of Certain Discount Vouchers for Prescription Drugs***, was signed into law on January 2, 2019. It charges the HPC with conducting an analysis and issuing a report evaluating the effect of drug coupons and product vouchers for prescription drugs on pharmaceutical spending and health care costs in Massachusetts.

1. Analyze the **total number and value of coupons** redeemed in the Commonwealth, and the **types of drugs** for which coupons were most frequently redeemed.
2. Compare any change in utilization of **generic versus brand name prescription drugs**, and any change in utilization among **therapeutically-equivalent brand name drugs**.
3. Analyze **effects on patient adherence**, and **access to innovative therapies**.
4. Study the **availability of coupons** or discounts upon renewals, and the **cost impact on consumers** upon expiration of coupons.
5. Analyze the **impact of drug coupons on health care cost containment goals** adopted by the Commonwealth, and commercial and GIC health insurance premiums and drug costs.

Framework for Analysis of Prescription Drugs that Offer Coupons

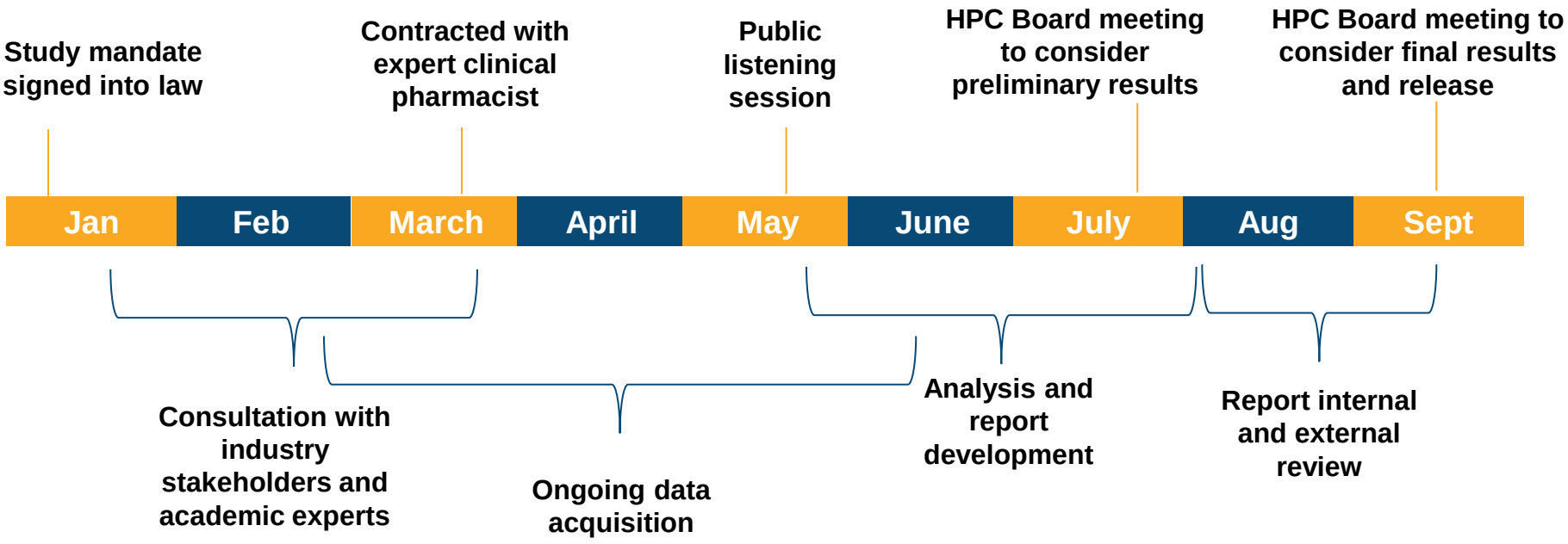
Study target: Branded drug that offers coupon	1 **Generic equivalent**	2 **Close therapeutic substitute: Generic**	3 **Close therapeutic substitute: Branded**	4 **No close therapeutic substitute**
Example				
Drug with coupon	Lipitor (statin; AB generic available)	Lyrica (nerve pain; no AB generic available)	Repatha (PCSK9; no AB generic available)	Kalydeco (cystic fibrosis; no AB generic available)
Comparator	Atorvastatin (generic Lipitor)	Gabapentin (generic Neurontin)	Praluent	None
Notes	Not eligible in MA		Comparators may also offer coupons	
Distribution of drugs with coupons, by type (Based on USC publication, which examined 200 highest US expenditure drugs in 2014; of these, 90 drugs – all branded – offered coupons)	21% (19)	28% (25)	39% (35)	12% (11)

Source: Van Nuys, Joyce, Ribero and Goldman. University of Southern California Leonard D. Schaeffer Center for Health Policy & Economics. 2018. A Perspective on Prescription Drug Copayment Coupon. Available from: https://healthpolicy.usc.edu/research/prescription-drug-copayment-coupon-landscape/

HPC Data Sources for Drug Coupon Research

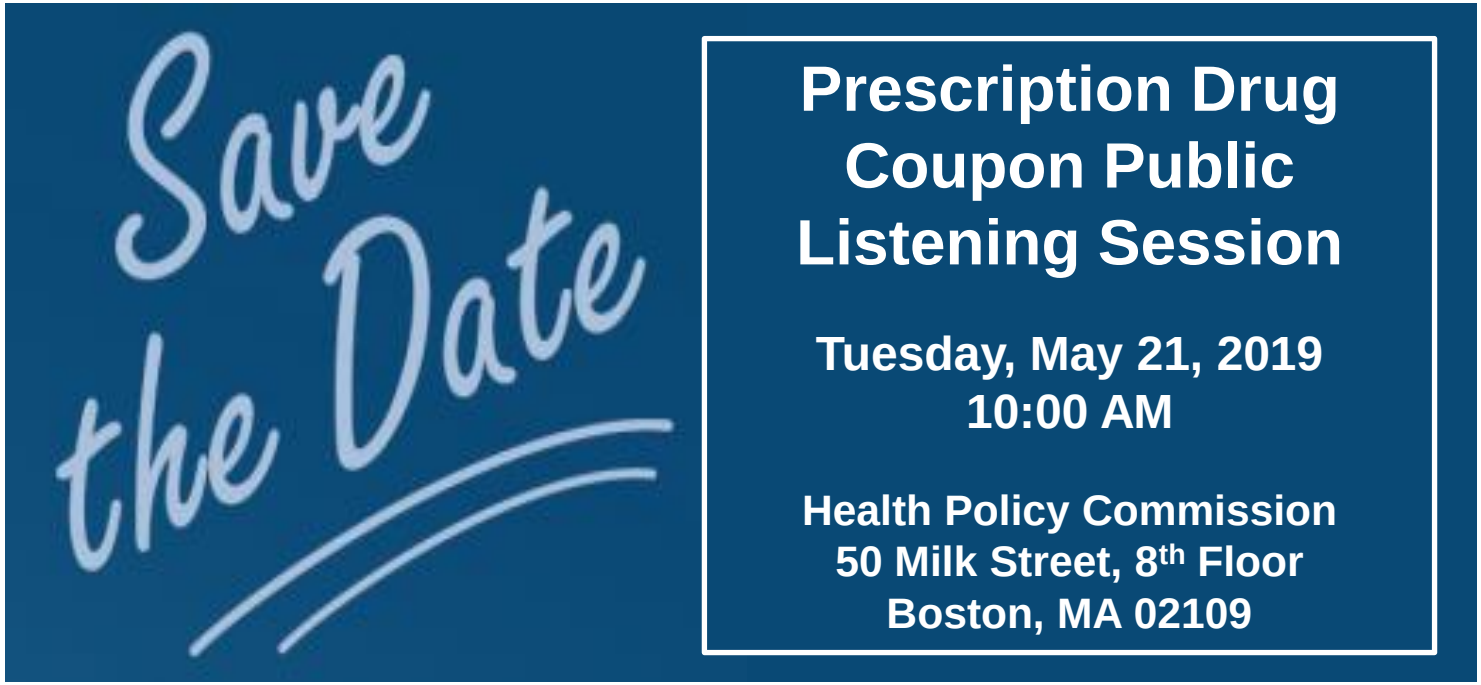
- All-Payer Claims Database
- Medicare Part D prescription data
- Vendor data
- Academic literature
- Public testimony

Prescription Drug Coupon Study Timeline



All dates are approximate

Listening Session on the Use and Impact of Prescription Drug Coupons



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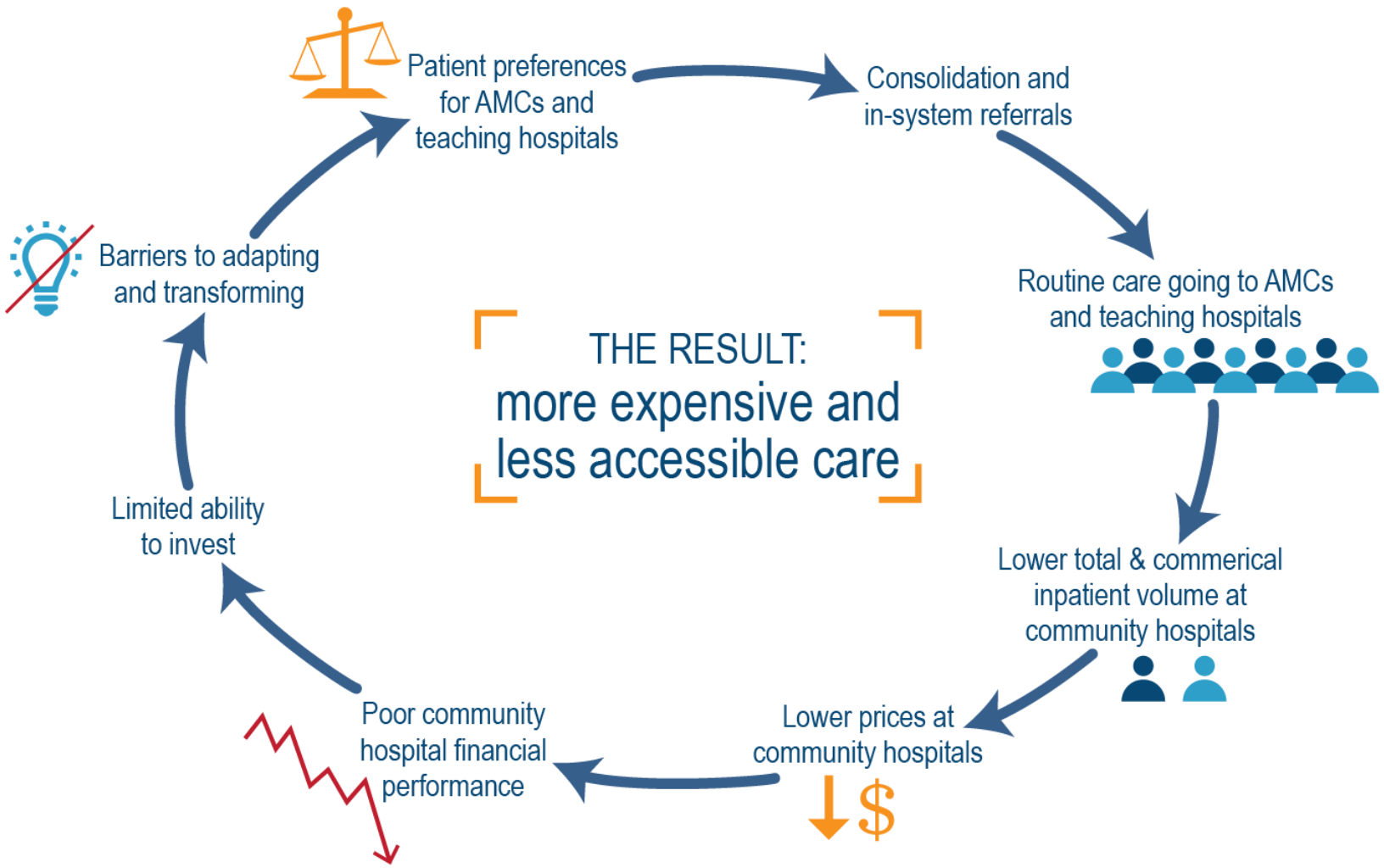
Since the HPC started monitoring the health care market in 2013 there have been some positive changes, but market dysfunctions persist

- Health care provider market changes, including consolidation and alignments between providers under new care delivery and payment models, have contributed to a **dynamic market** in Massachusetts.
- The HPC has reviewed **98 notices of material change** since April 2013, 40 of which involved hospital or physician affiliations.
- Hospitals are facing **unprecedented pressure to adapt** to new care delivery and payment models, with community and independent hospitals experiencing particular challenges driven by market dysfunctions.
- Physicians have been affiliating with hospitals and provider systems at a rapid rate; most primary care services in Massachusetts are now delivered by physicians **affiliated with major provider systems**.

Community hospitals continue to face self-reinforcing challenges that lead to more expensive and less accessible care



The Market Retrospective project will examine the impact of major health care market changes in Massachusetts since the creation of the HPC

Primary Goals of the Market Retrospective Project

- Respond to commissioner and stakeholder interest in the **impacts of past transactions**
- Respond to commissioner and stakeholder interest in updating analyses from the ***Community Hospitals at a Crossroads* report**
- Highlight **areas of persistent market dysfunction** to emphasize the need for continued reform and investment

Material Changes Received to Date

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Clinical affiliation	22	22%
Physician group merger, acquisition or network affiliation	20	20%
Acute hospital merger, acquisition or network affiliation	20	20%
Formation of a contracting entity	18	18%
Merger, acquisition or network affiliation of other provider type (e.g., post-acute)	12	12%
Change in ownership or merger of corporately affiliated entities	5	5%
Affiliation between a provider and a carrier	1	1%

The Market Retrospective project will include analyses related to a cross-section of the HPC's policy interests

Potential Priority Areas

- Descriptive analyses of **recent changes in the Massachusetts health care market landscape** (e.g., changes in overall utilization of hospital and non-hospital care, patient migration patterns, and spending)
- Analyses of the **impacts of provider consolidation** and the extent to which expected benefits have (or have not) been realized
- An examination of **disparities** among provider systems, **impacts** on the patients they serve, and the **need for continued development** of robust, efficient community health systems

The HPC expects multiple opportunities to discuss results of these analyses, including the 2019 Health Care Cost Trends Hearing, public meetings of the HPC's Board, and various publications.

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Statutory language directing the HPC to study the statewide availability of providers treating co-occurring mental illness and substance use disorder

Chapter 52 of the 2016 Session Laws, ***An Act Relative to Substance Use, Treatment, Education and Prevention***, charges the HPC, in consultation with the Department of Public Health and the Department of Mental Health, with assessing the availability of providers treating "dual diagnosis," or co-occurring mental illness and substance use disorder (SUD).

1. Create an **inventory of health care providers capable of treating patients (child, adolescent, and/or adult) with dual diagnoses**, including the location and nature of services offered at each such provider.

2. **Assess sufficiency of and barriers to treatment**, given population density, geographic barriers to access, insurance coverage and network design, and prevalence of mental illness and SUD.

3. **Make recommendations to reduce barriers to care.**

Importance of integrating mental health and SUD treatments

- Patients with mental illness are at higher risk than the general population for SUD, and vice versa.[1] Nationally, co-occurring disorders affect ~18% of adults with mental illness and ~43% of adults with SUD.[2]

- **Approximately 20% and 10% of Massachusetts adults reported past year mental illness or SUD, respectively.** Based on these figures, the estimated total number of Massachusetts adults with a co-occurring disorder is at least 236,000.[3]

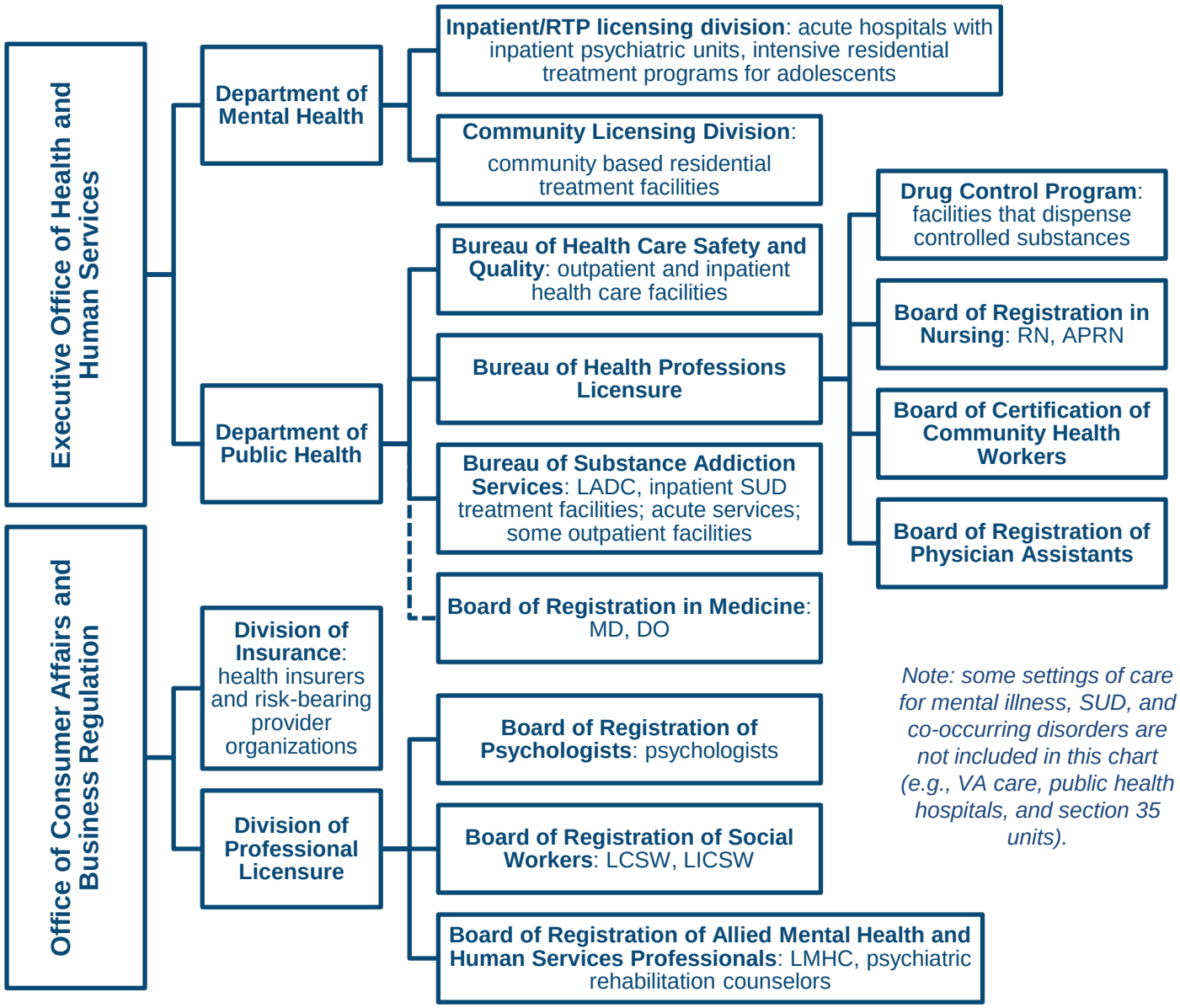
- The clinical presentations of mental illness and SUD can confound each other: without proper training in recognizing both, providers may misinterpret symptoms, misdiagnose patients, and provide suboptimal treatment.[4]

- Complications of untreated mental illness and substance use:
  - Self-medication by individuals with untreated or under-treated mental illness can affect the presentation and severity of their psychiatric symptoms.[5]
  - Patients with untreated or under-treated SUD are more likely to violate the rules of psychiatric programs or facilities and to drop out of treatment.[6]

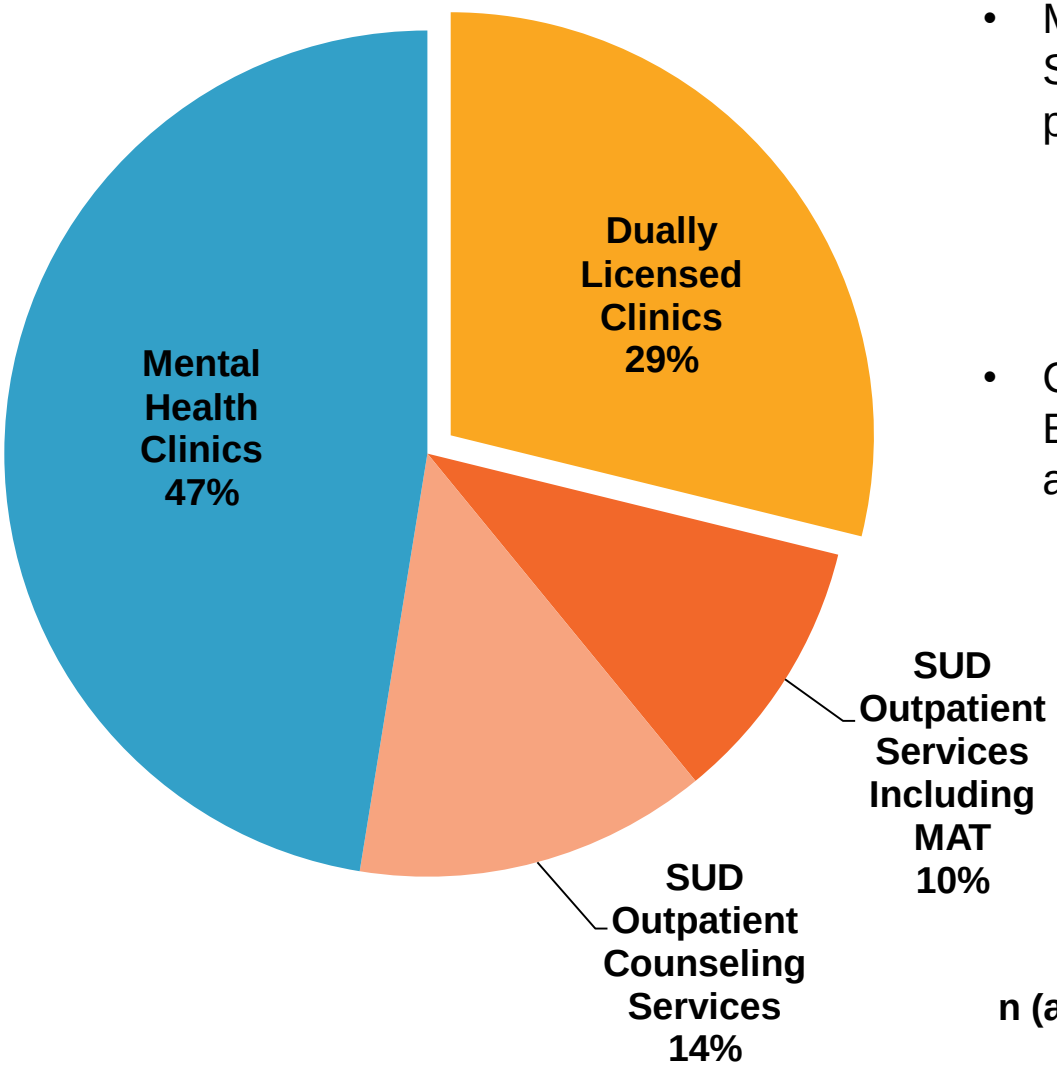
TREATMENT OF ONE DISORDER WHILE SCREENING FOR AND, AS APPROPRIATE, TREATING THE OTHER, PRODUCES OPTIMAL CARE.

1. Merikangas KR, et al. (1998). Comorbidity of substance use disorders with mood and anxiety disorders: results of the International Consortium in Psychiatric Epidemiology, *Addictive Behaviors*, 23, 893-907.
2. SAMHSA. *Substance Use and Mental Health Indicators in the United States: Results from the 2016 National survey on Drug Use and Health*. "Past Year SUD and Mental Illness among Adults 18 and older, 2016.". September 2017.
3. MA estimations interpolated based on data from: SAMHSA. 2015-2016 National Survey on Drug Use and Health: Model-Based Prevalence Estimates. Available: https://www.samhsa.gov/data/sites/default/files/NSDUHsaePercents2016/NSDUHsaePercents2016.pdf
4. Crawford V, Crome IB, & Clancy C (2003). Co-existing problems of mental health and substance misuse (dual diagnosis): a literature review. *Drugs: Education, Prevention, and Policy*, 10, S1-S74.
5. National Institute of Drug Abuse (2011). Comorbidity: addiction and other mental disorders. *Drug Facts.*
6. Case N (1991). The dual-diagnosis patient in a psychiatric day treatment program: a treatment failure. *Journal of Substance Abuse Treatment*, 8 69-73.

Responsibilities for licensure of providers who treat mental illness and SUD are divided across multiple state agencies



Only a quarter of behavioral health clinics and counseling sites are licensed to treat both mental illness and SUD

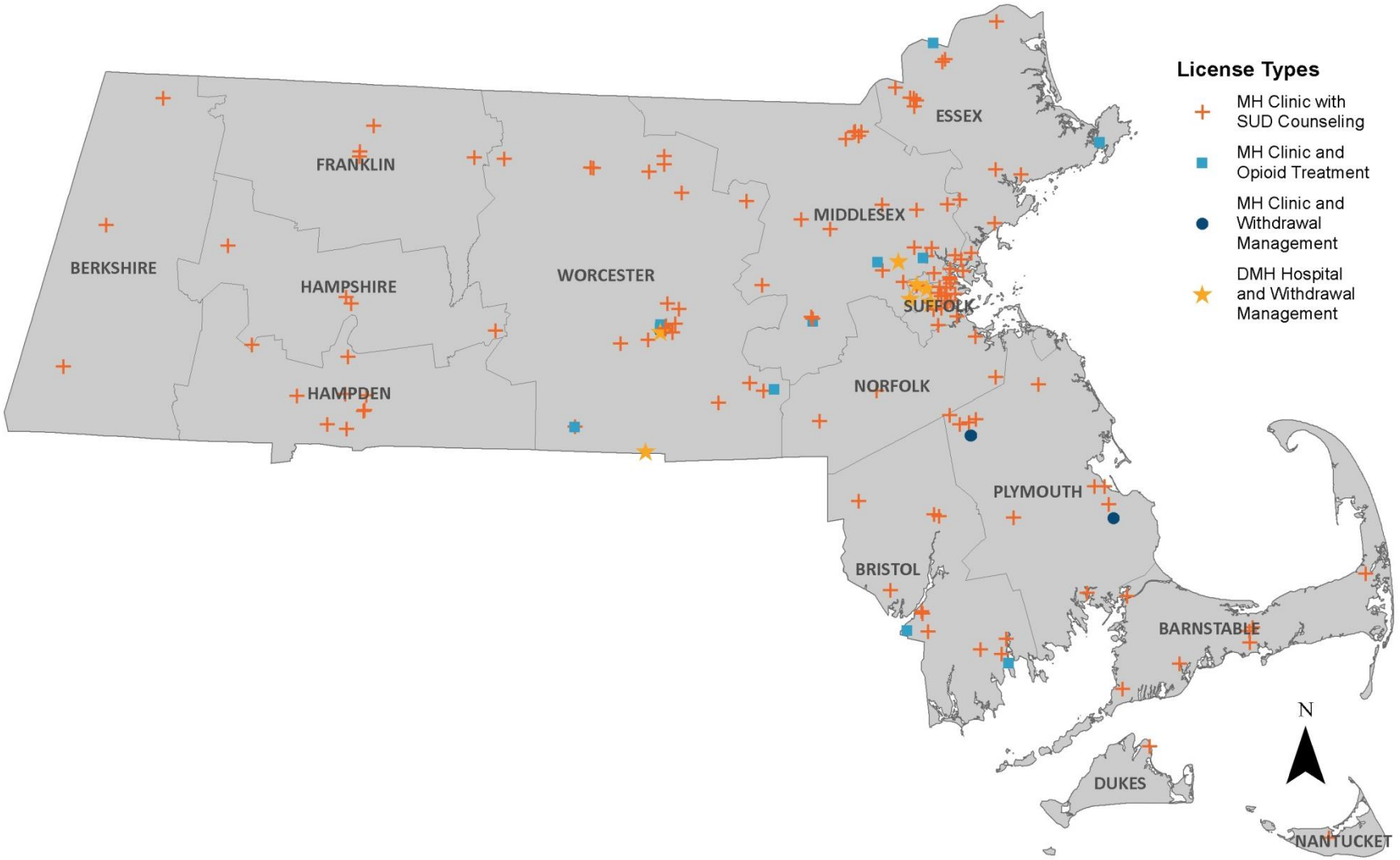


- Mental health clinics without an SUD license represent 50% of providers
  - These sites may still treat patients with SUD, per individual staff members' clinical licenses
- Clinics with dual licensure follow BSAS requirements for staffing and treatment protocols

n (all license types) = 586

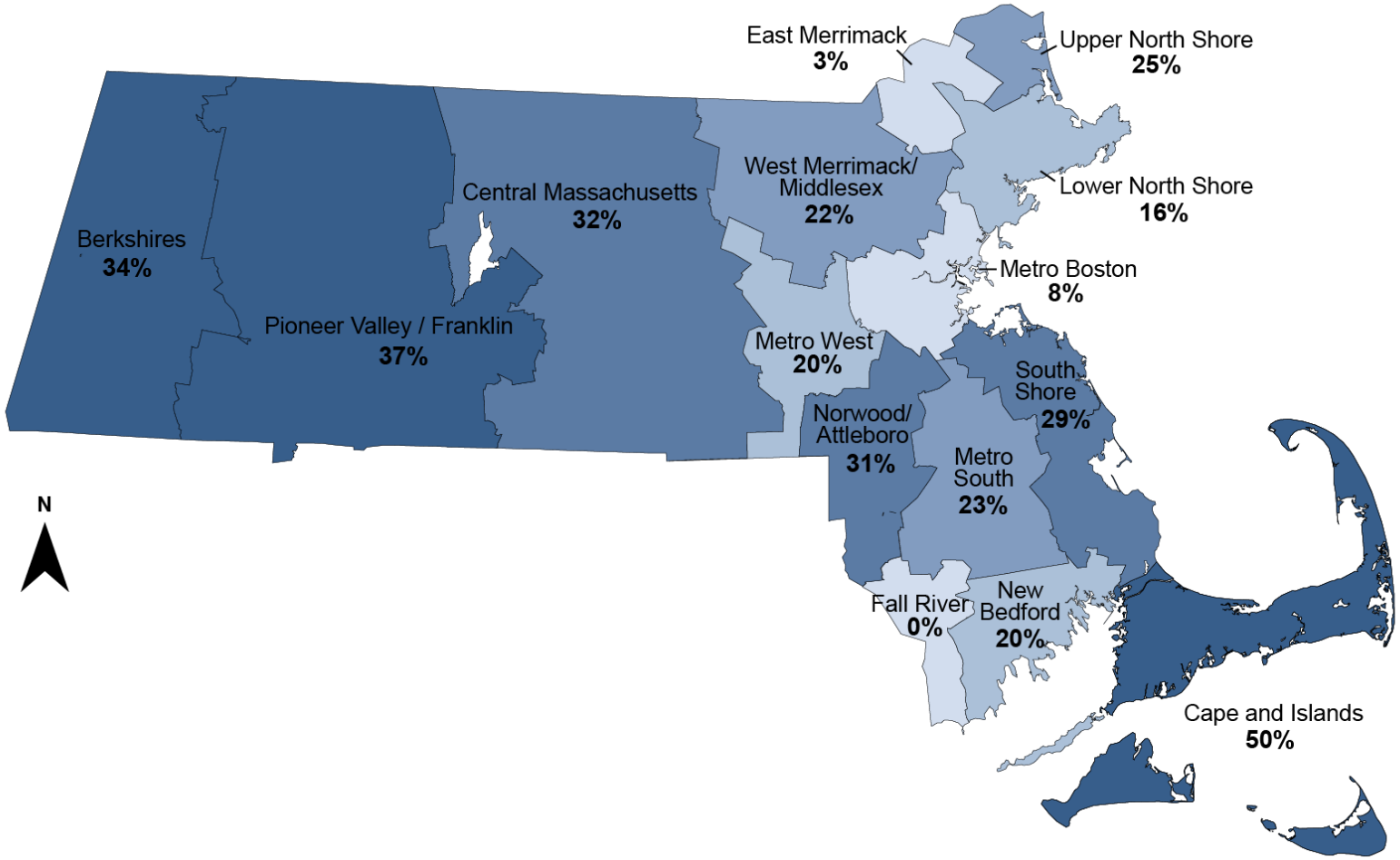
Source: HPC analysis of DPH (Division of Health Care Facility Licensure and Certification and Bureau of Substance Addiction Services) licensing data.
Note: while community health centers (CHC) that have mental health or SUD licenses are included, any CHC or primary care provider not licensed as a mental health or SUD clinic is not included, regardless of whether it provides prescribing for mental health or SUD.

Locations of all dually licensed provider sites in Massachusetts, 2018



Source: HPC analysis of DPH (Division of Health Care Facility Licensure and Certification and Bureau of Substance Addiction Services) and Department of Mental Health licensing data.

Percent of population over 18 who live more than a 15 minute drive from the nearest dually licensed clinic, 2018



Note: There are 15 HPC regions, which are based on patterns of patient travel for inpatient care. For more information on how HPC created these regions, please see: http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-technical-appendix-b3-regions-of-massachusetts.pdf. Driving distance is based on HPC analysis of population by zip code from American Community Survey, 5 year estimates, 2016, U.S. Census Bureau

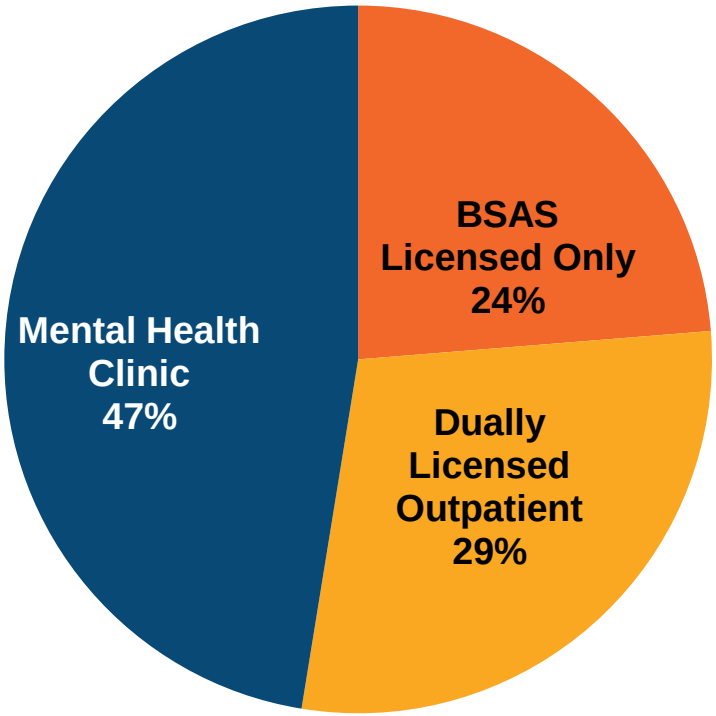
Survey Methodology

- HPC combined data from **commercial payers' provider directories** and data from the Substance Abuse and Mental Health Services Administration (SAMHSA) with **state licensing data** from DMH and multiple bureaus within DPH.
- HPC cross-referenced these files by address and provider name to identify the number of licensed provider sites by type(s) of license and HPC region.
- HPC contracted with a expert vendor to create a **survey for providers** that would determine:
  - services provided
  - populations served
  - the extent to which services specifically for co-occurring disorders are provided
  - barriers to providing integrated care for co-occurring disorders
- The survey received responses from 405 sites of service, representing **slightly more than 50% of licensed behavioral health treatment sites** in Massachusetts.
- In addition, the survey received responses from 170 independent clinicians in active practice who represent an important component of commercial payers' behavioral health provider networks.

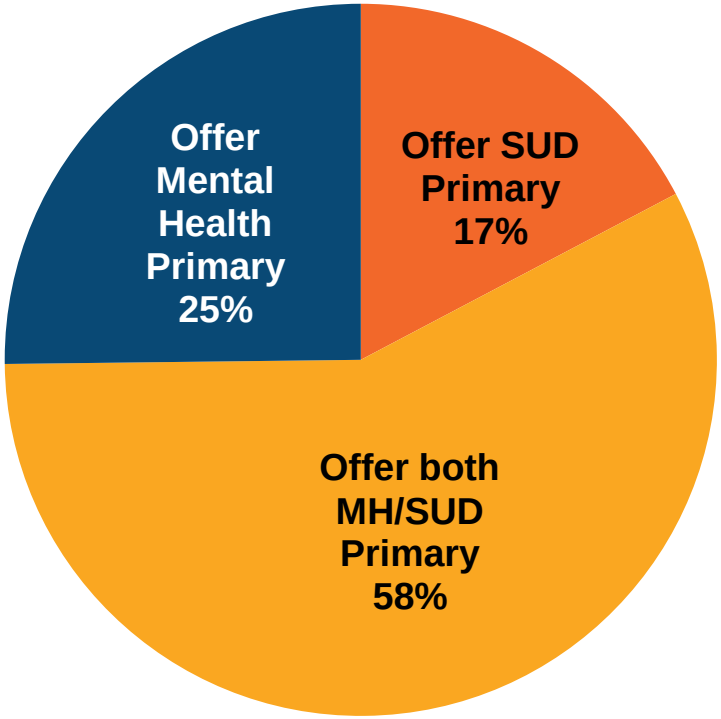
Providers reported offering both mental health and SUD services at a higher rate than the dual licensure rate would suggest

Clinics that are licensed only to provide mental health services are allowed to treat SUD, as their individual clinicians' professional licenses authorize them to treat *any* behavioral health diagnoses. While these sites may choose not to pursue parallel BSAS licensure, they still serve patients with co-occurring disorders.*

Licensed Clinic By Types, as of October 2018, N=586

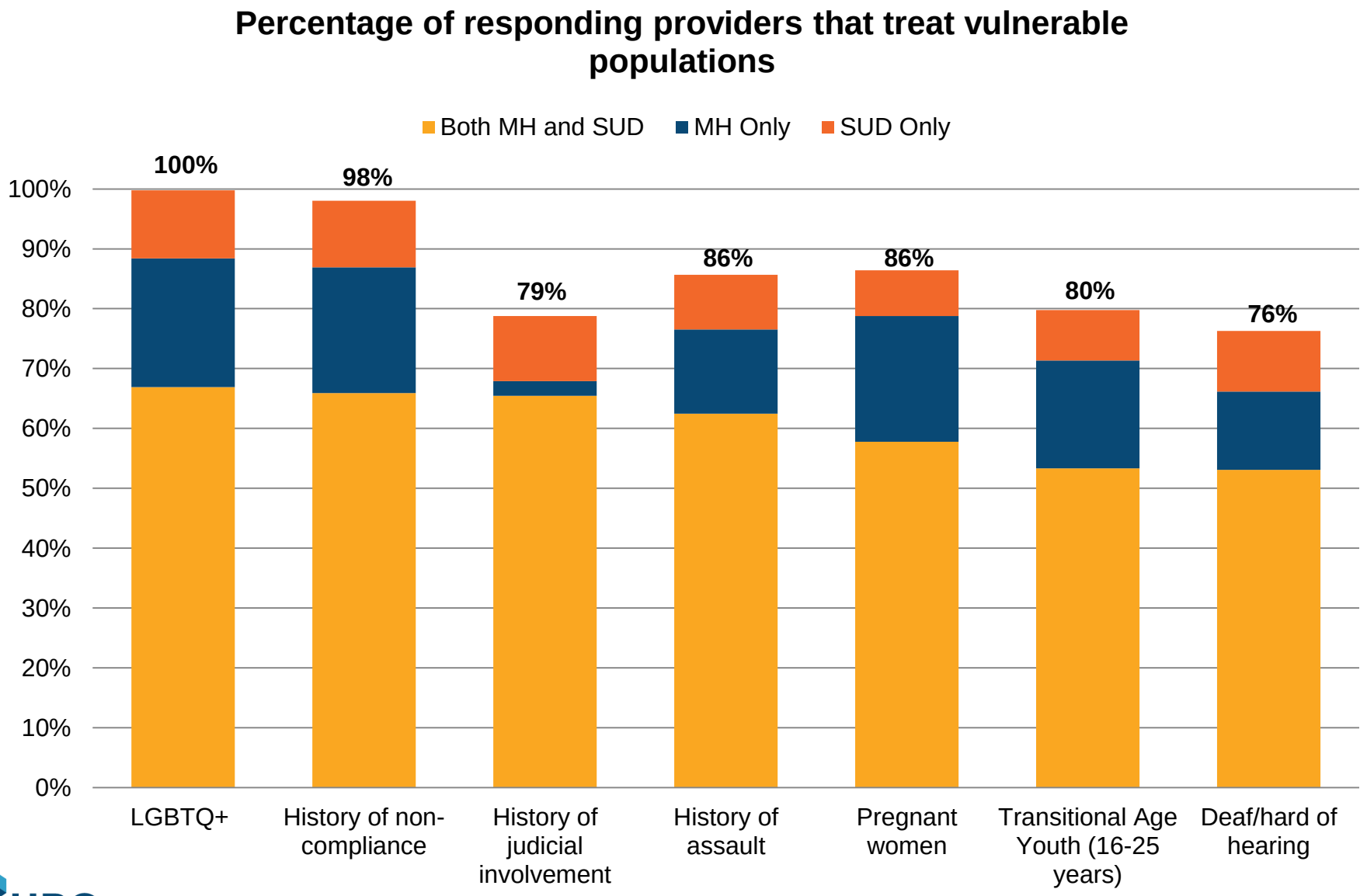


Survey respondents by Primary Service, N=405

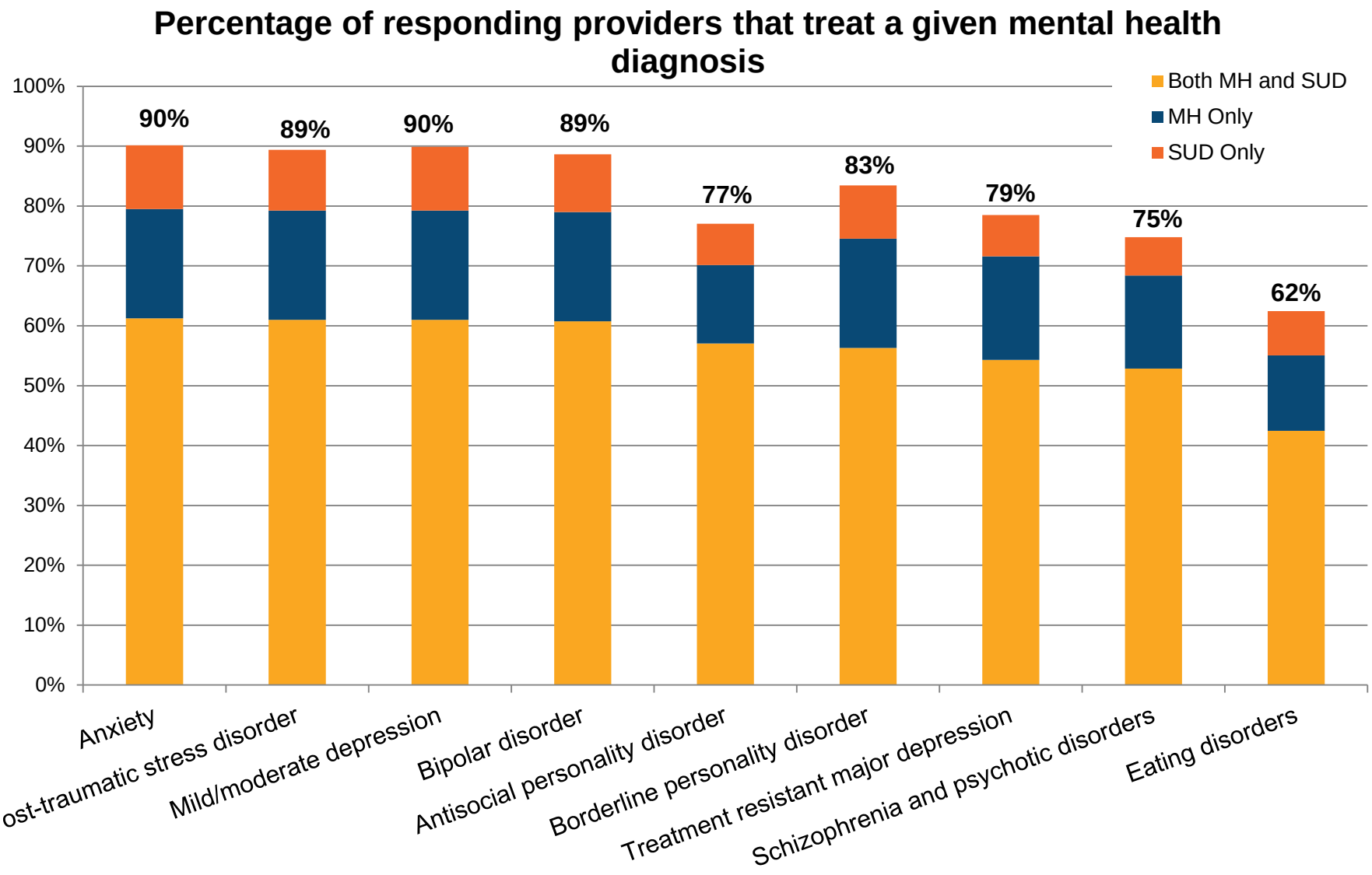


* This is also true for clinics that are licensed to provide SUD services and do not seek parallel mental health clinic licensure.

Providers reported different rates of treating particular vulnerable populations



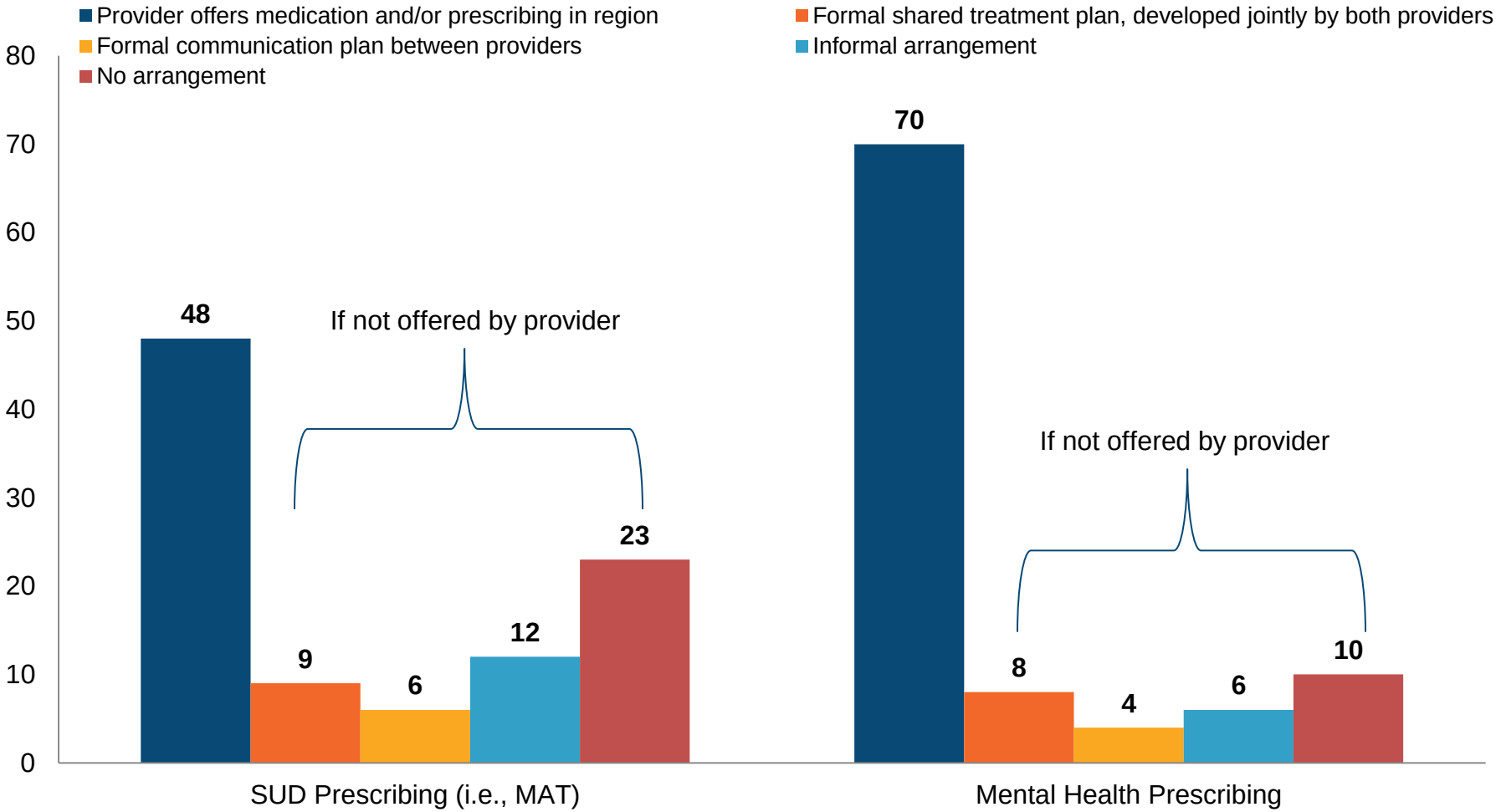
Providers reported different rates of treating particular mental illnesses



Note: a similar analysis on substance treated showed little variation by substance.

Providers reported a range of prescribing arrangements; some have no arrangements for providing medication

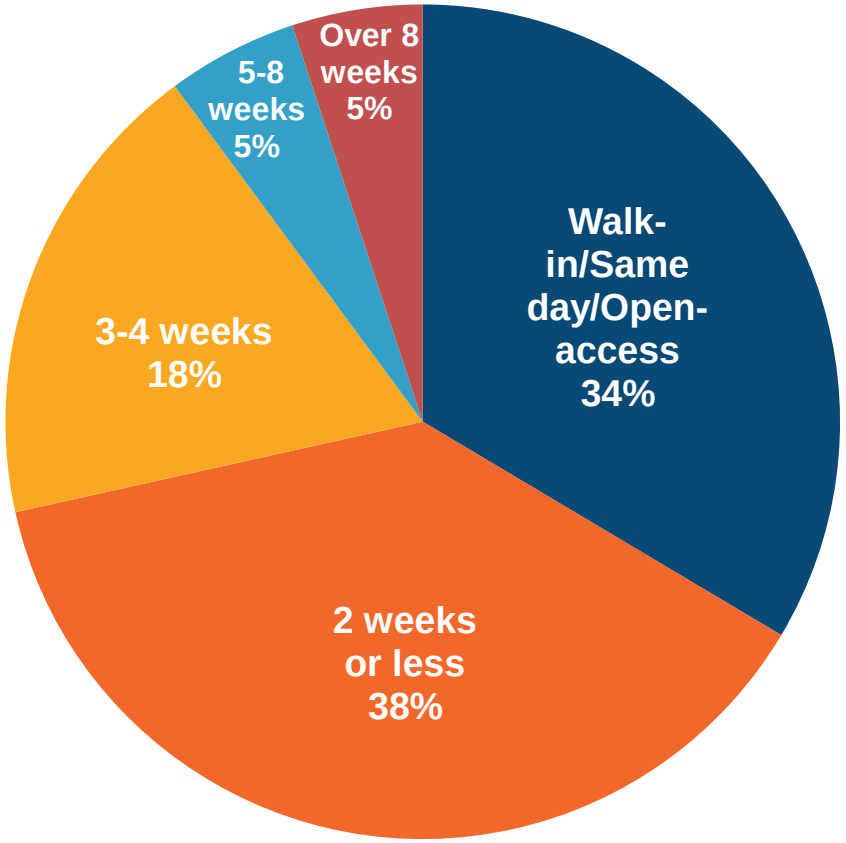
Prescribing and medication arrangements of providers who report serving co-occurring disorder (n=98*)



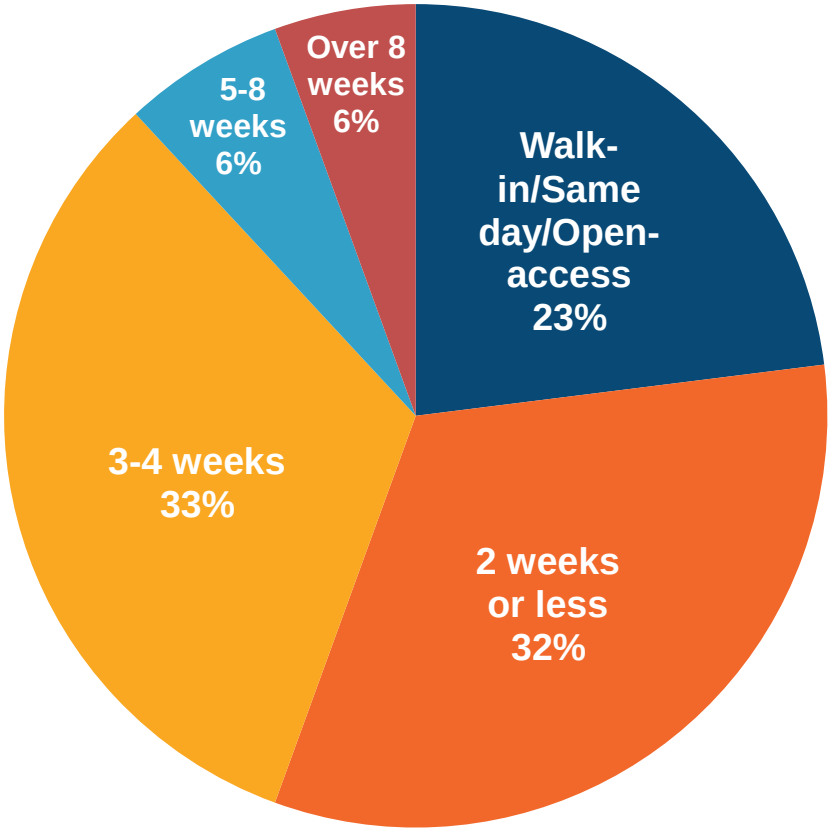
*Of all survey respondents that reported offering outpatient services for mental health and SUD, 98 responded to both 1) a question about SUD prescribing and 2) about mental health prescribing.

Patients at responding providers' sites face longer waits for co-occurring disorders care if they do not speak English

Time to first appointment for adults with co-occurring disorders who speak English



Time to first appointment for adults with co-occurring disorders who do not speak English



Note: the survey did not distinguish between prescribing versus non-prescribing services within questions about access based on language needs.

Summary of Recommendations

Licensing and Regulation

- The Commonwealth should continue **to develop a systematic approach to identifying and monitoring** prevalence of co-occurring disorders and the corresponding service capacity and availability.
- EOHHS should continue its efforts to **streamline the licensure process** for providers seeking both SUD and mental health licenses.

Integrated Care Models

- The Commonwealth should continue to **promote and fund evidence-based integrated care models** for the treatment of co-occurring disorders, particularly those that integrate care with community based organizations, primary care providers, and social service organizations.
- The Commonwealth should **strengthen access to behavioral health medication treatment** and recognize it as a standard of care.

Workforce

- The Commonwealth should continue to invest in developing a **diverse, well-trained, and supported** behavioral health workforce.

Payment Policy

- Payers should **improve reimbursement rates and payment policies** to encourage access to and integration of behavioral health care.

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Upcoming 2019 Meetings and Contact Information

Board Meetings

Wednesday, March 13 – Benchmark Hearing
Wednesday, April 3
Wednesday, May 1
Wednesday, July 24
Wednesday, September 11
Monday, December 16

Committee Meetings

Wednesday, February 27
Wednesday, June 5
Wednesday, October 2
Wednesday, November 20

Contact Us

Mass.Gov/HPC
@Mass_HPC
HPC-Info@state.ma.us

Special Events

Tuesday, May 21 – Prescription Drug Coupon Public Listening Session
2019 Cost Trends Hearing
Day 1 – Tuesday, October 22
Day 2 – Wednesday, October 23